

Montana Board of Medical Examiners
P.O. Box 200513 (301 S. Park, 4th Floor - Delivery) Helena, Montana 59620-0513
(406) 444-6880 FAX (406) 841-2305
EMAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

APPLICATION FOR RENEWAL OF RESIDENT PHYSICIAN LICENSE

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

RESIDENT PHYSICIANS ARE SUBJECT TO BOARD RULES ON SCOPE OF PRACTICE. (ARM 24.156.507)

In 2015, the Montana Legislature passed SB 77 at the request of the Board of Medical Examiners. Effective July 1, 2015, the bill established a Resident Physician license—and requirements for that license—in MCA 37-3-307. Previously, that statute governed “temporary licenses.”

The Resident license is valid for up to one year and may be renewed, at the Board’s discretion, for additional 1-year periods as long as the resident is in good standing in an approved residency program.

Beginning in 2016, the renewal deadline will be June 30. **The renewal fee is \$100.** Residents also may be required to pay a \$30 fee for the Montana Prescription Drug Registry at the time of renewal. To learn more about MPDR fees, visit <http://leg.mt.gov/bills/mca/37/7/37-7-1511.htm>

This application form reflects the changes brought by SB 77 that became effective July 1, 2015.

RENEWAL REQUIREMENTS:

All applicants wishing to renew a Resident Physician license must:

- Submit an application and fee to the Board.
- Provide a letter or other form of verification that the applicant will be enrolled in one of the following for the academic year (July 1-June 30) for which the renewal is requested:
 - 1) A Montana residency program in which the applicant will see patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in Montana; or
 - 2) An approved residency (one that is accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association) in which the applicant will see patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in Montana.

APPLICATION FEE: \$100.00 (\$130.00 if required to pay annual MDPR fee)

****Make payable to Montana Board of Medical Examiners****

DOCUMENTS:

The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

- **Letter or other verification of enrollment in an Approved Residency Program**

APPLICATION PROCEDURES:

The letter of Verification from your Approved Residency Program must state that you remain in good standing in your training program and that you will be enrolled in that program for the coming year. (July 1-June 30.)

Your application must include the name and address of the Montana-licensed Physician(s) who will be responsible for your supervision. The Physician's license must be current and unrestricted.

The Board office must be informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

Upon receipt of a completed application with all the supporting documentation, the application will be reviewed for compliance with the Board's statutes and rules.

The applicant will be notified in writing of any deficient or missing items from the application file.

For information with regard to the processing of this application, please contact the Business Standards Division Renewals Unit at (406) 444-6880 or email the Board office at dlibsmed@mt.gov

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Application for Renewal of Resident Physician License

FEE: \$100 (\$130 with MPDR fee.)
Renewal is valid for 1 year. (July 1-June 30)

1. FULL NAME:

LastFirstMiddle

2. ADDRESS:

Street or PO Box #City and StateZip

3. TELEPHONE:

4. E-MAIL:

5. INFORMATION ABOUT THE RESIDENCY ASSOCIATED WITH THIS RENEWAL:

NAME OF RESIDENCY PROGRAM:

ADDRESS:

CITY, STATE, ZIP:

RESIDENCY YEAR (i.e. 1,2,3): FROM JULY 1, TO JUNE 30,

6. MONTANA SUPERVISING PHYSICIAN(S)

Please enter the names and information about the Montana-licensed physician(s) who will supervise you during this year of your residency.

PHYSICIAN NAME:
LICENSE NUMBER:
PHYSICIAN NAME:
LICENSE NUMBER:

***** YOU MUST ANSWER ALL QUESTIONS BELOW BY CHECKING EITHER YES OR NO *****

IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS, PLEASE SUBMIT YOUR DETAILED WRITTEN EXPLANATION TO THE BOARD OFFICE.

Yes No Have any legal or disciplinary actions been instituted against you or any of your professional licenses since either your initial licensure in Montana or since you renewed your license, whichever occurred latest?

If so, please attach copies of the document that initiated each action and all final orders. Montana Code Ann. Sec. 37-1-105 requires that you report this information. Failure to accurately furnish this information is grounds for denial or revocation of your license.

Yes No Have you experienced any physical or mental condition during the last licensing period, not otherwise reported to the Board or the Montana Professional Assistance Program, which might adversely affect any aspect of your medical practice?

Yes No Have you, during the last licensing period, engaged in habitual intemperance, the excessive use of, or been under the influence of, any addictive or mind-altering substance while on duty or on call (not otherwise reported to the Board or the Montana Professional Assistance Program)?

Yes No Have you, during the last licensing period, lost, voluntarily relinquished, been refused, limited, restricted or denied privileges in any hospital or society?

Yes No Have you, during the last licensing period, lost, voluntarily relinquished, been refused, limited, restricted or denied any prescribing privileges?

Yes No Have you, during the last licensing period, voluntarily surrendered, cancelled, been limited or restricted, failed to renew or entered into a consent agreement with respect to your license during a disciplinary investigation or in lieu of disciplinary action or been denied a state license to practice or specialty board certification?

SIGNATURE_____ DATE